

# New Patient Form - Male



\_\_\_\_\_ Date of Visit \_\_\_\_\_

Name: \_\_\_\_\_ last first \_\_\_\_\_ What do you like to be called? \_\_\_\_\_ Date of birth? \_\_\_\_\_

Referring physician: \_\_\_\_\_ Primary care physician: \_\_\_\_\_

Other physicians you see and why you see them: \_\_\_\_\_

Special needs (wheelchair, etc.): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Current Problem

What is the main reason for your visit? \_\_\_\_\_ When did this start? \_\_\_\_\_

Describe the location of the problem: \_\_\_\_\_ How severe is the problem (using a scale of 1-10 with 10 being the worst)? \_\_\_\_\_

Is the problem present all the time? \_\_\_\_\_ If not, please explain and describe anything that makes the problem better or worse \_\_\_\_\_

Have you had any treatment for this condition? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Have you had any blood tests, X-rays or imaging for this problem? If so, what, where and when? \_\_\_\_\_

## PLEASE BRING ALL RECORDS/X-RAYS CD/FILMS TO YOUR APPOINTMENT

Please share anything else you think may be important about your problem. \_\_\_\_\_

If you are over 40, have you had a PSA blood test? N Y when and where? \_\_\_\_\_

Have you ever seen a urologist before? If so, who, when and what for? \_\_\_\_\_

### Do you currently have any of the following symptoms? If yes, please explain below.

Fever or chills?	Y N	Are you awakened at night to urinate? How many times? _____	Y N
Pain in the side or back?	Y N	Excessive urge to urinate?	Y N
Blood in the urine?	Y N	Leaking of urine?	Y N
Pain during urination?	Y N	Excessive frequency of urination	Y N
Straining to urinate?	Y N	How many times in 24 hours? _____	
Difficulty emptying bladder?	Y N	Problems with erections?	Y N
		Problems with ejaculation?	Y N

### Have you ever had any of the following? If yes, please explain below.

Bladder infections?	Y N	Surgery of the urinary tract?	Y N	Kidney Stones?	Y N
Kidney infections?	Y N	Cancer of the urinary tract?	Y N	Other urologic problems?	Y N
Sexually transmitted disease?	Y N				

### Medications (please include over the counter medications and supplements, include separate sheet of paper if more space is needed)

<i>Medication</i>	<i>Dosage</i>	<i>Freq.</i>	<i>Medication</i>	<i>Dosage</i>	<i>Freq.</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you take any blood thinners? (aspirin, Coumadin, Plavix, etc.) Y N Type \_\_\_\_\_

**ALLERGIES**

**MEDICAL CONDITIONS AND PAST MEDICAL HISTORY,**

**If yes to any, please explain below.**

Diabetes	Y	N	Emphysema/COPD	Y	N	_____
High blood pressure	Y	N	Asthma	Y	N	_____
High cholesterol	Y	N	Major trauma	Y	N	_____
Heart valve problem	Y	N	Parkinson's disease	Y	N	_____
Heart attack	Y	N	Stroke/TIA	Y	N	_____
Hepatitis	Y	N	HIV	Y	N	_____
Bleeding tendency	Y	N	Depression	Y	N	_____
Blood clots	Y	N	Psychiatric disorders	Y	N	_____
Pacemaker/difib implant	Y	N	Glaucoma	Y	N	_____
			Heart Problems	Y	N	_____

Have you ever had cancer? \_\_\_\_\_ type? \_\_\_\_\_ status? \_\_\_\_\_

**OTHER MEDICAL PROBLEMS**

\_\_\_\_\_  
\_\_\_\_\_

**PRIOR SURGERIES (please include date)**

\_\_\_\_\_  
\_\_\_\_\_

**HABITS** Smoking N Y QUIT If quit, what year? \_\_\_\_\_ Packs per day? \_\_\_\_\_ How many years did (have) you smoke(d)? \_\_\_\_\_

Alcohol N Y Drinks per week? \_\_\_\_\_ Recreational drugs? \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ No. of Children \_\_\_\_\_

Have you ever been exposed to radiation or environmental toxins NO YES \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Has anyone in YOUR FAMILY (other than yourself) ever had the following?

Kidney Stones \_\_\_\_\_ Cancer of the kidney or bladder \_\_\_\_\_ Cancer of the prostate? \_\_\_\_\_

**Mother:** age \_\_\_\_\_ if deceased, age \_\_\_\_\_ cause \_\_\_\_\_ **Father:** age \_\_\_\_\_ if deceased, age \_\_\_\_\_ cause \_\_\_\_\_

**Do you currently have any of the following symptoms? If so, please explain below:**

Problems with general health	Y	N	Abdominal pain	Y	N	Seizures	Y	N
Recent weight change	Y	N	Diarrhea	Y	N	Tremors	Y	N
Fatigue	Y	N	Constipation	Y	N	Numbness/tingling	Y	N
Sore throat	Y	N	Poor appetite	Y	N	Depression	Y	N
Recent cold	Y	N	Heat/cold intolerance	Y	N	Insomnia	Y	N
Irregular heart beat	Y	N	Joint pain/stiffness	Y	N	Thyroid disease	Y	N
Chest pain	Y	N	Back pain	Y	N	Excessive thirst	Y	N
Shortness of breath	Y	N	Rash	Y	N	Anemia	Y	N
Chronic cough	Y	N	Itching	Y	N	Past blood transfusion	Y	N
Nausea/Vomiting	Y	N	Frequent headaches	Y	N	Easy bleeding/bruising	Y	N

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_